Center for Grief and Trauma Therapy

5500 Skyline Drive
Suite 4
Wilmington, DE 19808
302-635-0505
contact@centerforgrieftherapy.com
www.centerforgrieftherapy.com

FEDERAL TAX ID: 81-3077315
GROUP NPI#: 1932550027

More details about your estimate

Patient name:

Date of Birth:

Out-of-network provider(s) or facility name: Center for Grief and Trauma Therapy

The amount below is only an estimate; it is not an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate.**

Contact your health plan to find out how much, if any, your plan will reimburse you should you submit paperwork for out of net reimbursement. IF you require documentation please contact the front desk at 302-635-0505 or contact@centerforgrieftherapy.com

GOOD FAITH ESTIMATE
TABLE OF SERVICES AND FEES

Client Name:

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress &)
	90791	Initial Diagnostic Evaluation	190.00
	90832	Psychotherapy, 16-37 minutes	82.50
	90834	Psychotherapy, 38-52 minutes	125.00

	90837	Psychotherapy ≥ 53 minutes (This fee is my hourly rate & used for all prorated calculations as indicated)	165.00
	90839	Psychotherapy for a Crisis (30-74 minutes)	165.00
	+90840	Psychotherapy for a Crisis (add on code for each additional 30 mins)	82.50

	90846	Family Psychotherapy without Patient Present, 50 minutes	165.00
	90847	Family Psychotherapy with Patient Present, 50 minutes	165.00
	90853	Group Psychotherapy	60.00
	98966-98968	Telephone Assessment & Management	Prorated based on the amount of time spent at the hourly rate per 15 minutes
	98970-98972	Online Digital Evaluation & Mgt (Responding to Email & Text Messages)	Prorated based on the amount of time spent at hourly rate per 15 minutes
	CancelationFee	Your Therapist Requires a 24-Hour Cancelation Fee	You are Responsible for the Fee of the Appointment Missed- $165.00
	Production of Records		0
	Total Estimate:	This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.	

Patient's signature or Guardian/
Authorized Representative signature

Date and Time of Signature

Print Name